161 Regional (Nonarticular) Rheumatism

JOE G. HARDIN

Definition

Most regional or local rheumatic symptoms are nonarticular, though monoarticular arthritis could be considered regional. For the purposes of this discussion, a regional rheumatic disorder is defined as a nonarticular rheumatism that is confined to one or a limited number of sites or regions in the body. The majority of rheumatic complaints fit just such a pattern. The common sites of regional rheumatic pain and their common disorders are listed in Tables 161.1 and 161.2.

Technique

In most situations, once it becomes relatively apparent that the problem is rheumatic, regional and nonarticular, only a few other questions need be asked. Premorbid patterns of usage or exercise, previous medical therapies, current disability, and prior history of regional rheumatism should be asked about. In general, a basic "rheumatism history" should suffice, but four special situations serve as exceptions to this rule.

Lumbar or low back pain is the most common regional rheumatic syndrome seen by many physicians. While many cases defy diagnosis, some of the most common and serious definable causes are suggested by the history. Neurologic symptoms in the lower extremities are especially important in the case of a suspected herniated nucleus pulposus or spinal stenosis. Patterns of leg radiation, localized weakness, and sensory deficits should be addressed. In the young patient with a gradual onset of lumbar pain, an arthritis (ankylosing spondylitis) should be considered. The location of the affected joints, especially the sacroiliacs, renders an articular localization by history and physical examination very difficult. Sacroiliitis, however, typically causes pronounced morning stiffness, and its pain is usually partially relieved by gentle lumbar motion. A family history of a spondyloarthropathy contributes significantly to the diagnostic specificity of these symptoms. Lumbar pain resulting from disc or bone infection is usually associated with fever. Metastatic disease to the spine is typically accompanied by other symptoms, suggesting a malignancy. Vertebral compression fractures caused by osteoporosis are common causes of back pain, and dietary and menstrual histories may be pertinent in women with this symptom. Trauma is especially important to address in this syndrome. For medicolegal as well as diagnostic purposes, the interviewer must approach the complaint of lumbar pain with compulsive thoroughness.

Myofascial pain (Table 161.2) is a common regional rheumatic disorder, perhaps the most common. But myofascial pain is also a prominent component of a widespread or generalized rheumatic syndrome known as *fibromyalgia* or *fibrositis*. Patients with this syndrome complain of pain in the vicinity of several of the trigger points listed in Table 161.2; in a sense they have a generalized "regional" disorder. They also have a number of other symptoms that help confirm the diagnosis. These include various patterns of emotional distress, disturbed sleep, headaches, subjective sensations of swelling, easy fatigability, and chronic tiredness.

Regional shoulder girdle pain in older patients has two important causes. Cervical osteoarthritis with its attending osteophytic foraminal nerve root encroachment may result in pain referred into one or both shoulder girdles. Inquire into the relationship of the pain to head and neck motion and position, and ask about specific neurologic symptoms in the arm and head. Polymyalgia rheumatica is a poorly

Table 161.1
Some Common Regional Rheumatic Syndromes

Region	Syndrome	Location	Clinical signs of inflammation
Hand–wrist	Thumb abductor or extensor tenosynovitis	Radial side of wrist and hand	Yes
Elbow	Tennis elbow	Enthesis of lateral epicondyle	No
	Olecranon bursitis	Overlying the olecranon process	Yes
Shoulder	Rotator cuff tendinitis	Superior aspect of humeral head	No
	Bicipital tenosynovitis	Proximal arm lateral to shoulder joint	Maybe
Hip	Trochanteric bursitis	Greater trochanter of femur	No
	Ischial bursitis	Ischial prominence	No
Knee	Prepatellar bursitis	Anterior to patella	Yes
	Anserine bursitis	Medial aspect of knee distal to joint line	Maybe
Ankle–foot	Achilles tendinitis	Posterior aspect of heel (achilles tendon or its insertion or enthesis)	No
	Plantar fasciitis	Plantar aspect of heel (plantar fascia insertion or enthesis)	No

Table 161.2
Common Sites of Myofascial Trigger Points

One or 2 cm distal to the lateral epicondyle of the humerus in the extensor digitorum muscle
The midpoint of the upper border of the trapezius
The second costochondral junction
At the origins of the supraspinatus muscle above the scapular spine, near its medial border
The presacral area in the upper outer quadrant of the buttock
Over the medial collateral ligament of the knee, proximal to the joint line
Over the spines and interspinous ligaments of the lower cervical vertebrae
Over the interspinous ligaments of L4–S1 in the lumbar area

understood disease that usually occurs in elderly Caucasians. Its major symptom is diffuse severe rheumatic pain, which tends to predominate in the shoulder girdles. Accompanying symptoms include fever, malaise, anorexia, weight loss, and the symptoms of giant cell arteritis, which is sometimes associated with polymyalgia. Symptoms of giant cell arteritis include headache, visual loss, facial pain—particularly claudication of the muscles of mastication—and manifestations of central nervous system involvement.

Myalgia or pain arising from skeletal muscle tends not to localize as well as other forms of nonarticular rheumatism, but it is not a common primary rheumatic problem, except perhaps in instances of apparent trauma or overuse. Severe regional myalgia suggests trauma or, less often, local infection. Generalized myalgia may result from vigorous exercise, rhabdomyolysis, viral and other systemic infections, the connective tissue diseases, and systemic vasculitis.

Basic Science

Causes of the common regional rheumatic disorders and their pathogenetic mechanisms were discussed in Chapter 159. The cause of most lumbar pain is never known, and diagnosable low back pain obviously has a variety of causes. Articular inflammation (spondylitis) tends to result in a historically distinctive syndrome that is prominently rheumatic, whereas the other recognized causes result in a syndrome that has fewer rheumatic features and is often referred to as *mechanical*. "Mechanical" low back pain is often associated with intraspinal compression of one or more lumbosacral nerve roots, which can worsen the back pain while causing more distal neurologic symptoms.

Compared to many other areas of medicine, the basic science of nonarticular rheumatism is in a primitive state. The more serious and disabling problems, such as lumbar pain, are beginning to attract research attention, however, and the future should see more precise correlations made between symptoms and specific anatomic derangements.

Clinical Significance

Little more need be said concerning the significance of the regional rheumatic disorders. Lumbar pain is usually transient, undiagnosable, and relatively trivial, but serious disorders can also cause lumbar pain. The history will usually suggest the serious causes. Shoulder girdle pain in the elderly may also have serious implications, and again the history usually points toward such diagnoses. Although not destructive in nature, fibrositis can be a lengthy and difficult illness, and the major indicators of its diagnosis are obtained from the interview. Otherwise, nonarticular rheumatism tends to be regional, transient, and easily treatable; significant pain and disability can be avoided by early recognition and appropriate therapy.

References

Kelley WN, Harris ED Jr, Ruddy S, et al., eds. Textbook of rheumatology, 3rd ed. Philadelphia: W.B. Saunders, 1989;Chaps. 24, 25.

McCarty DJ, ed. Arthritis and allied conditions. A textbook of rheumatology, 11th ed. Philadelphia: Lea & Febiger, 1989;55–68.

Morgan WL Jr, Engel GL. The clinical approach to the patient. Philadelphia: W.B. Saunders, 1969.

Polley HF, Hunder GG. Rheumatologic interviewing and physical examination of the joints. 2d ed. Philadelphia: W.B. Saunders, 1978.

Sheon RP, Moskowitz R, Goldberg V, eds. Soft tissue rheumatic pain: Recognition, management, prevention. 2d ed. Philadelphia: Lea & Febiger, 1987.